Editorial

Anticholinergic Side Effects in Perspective

Some of our readers may read the cover and table of contents for this issue of *The Primary Care Companion to The Journal of Clinical Psychiatry* and sense that they have received a journal of pharmacology by mistake. Further examination of the contents will be reassuring, but I felt it necessary to justify to our readers the presence of a seemingly esoteric study of anticholinergic side effects of 2 atypical antipsychotics—risperidone and olanzapine. This is, after all, a journal dedicated to primary care neuropsychiatric illness.

The article by Kennedy et al. is clinical in nature, comparing anticholinergic adverse events experienced by schizophrenic patients taking 2 different medications for which in vitro and in vivo data and experience are at odds. The comparison and the clinical rationale supporting the investigation are sound. Clinicians use perceived side effect profiles as part of the selection process in treatment protocols. Studies of this kind help establish links between bench work studies and clinical trials. Information on expected anticholinergic effects may inform a decision about appropriateness for certain patient groups, such as the elderly. When such investigations might help our readership offer more exacting care to their patients, we are happy to review and publish the results.

Another factor in the decision to publish this article on atypical antipsychotics is the topic of atypical antipsychotics themselves. These "novel neuroleptics," introduced by clozapine in the 1980s, have surpassed older agents except possibly in the use of depot forms of haloperidol or fluphenazine when adherence is problematic. Clozapine is now considered the gold standard neuroleptic where efficacy is concerned. Problems of clozapine-associated agranulocytosis may have limited the use of clozapine to and within the specialty of psychiatry, however. Significantly, the newer atypical antipsychotics risperidone, olanzapine, and quetiapine do not have agranulocytosis as a major concern.

Atypical antipsychotics offer several additional advantages over older neuroleptics. They are associated with a lower incidence of the extrapyramidal syndrome—in most patients obviating the need to add additional anticholinergic or dopaminergic medications to treat this side effect common to older agents. They are also associated with a lower risk of tardive dyskinesia—the dreaded and treatment-refractory complication of neuroleptic therapy. Prolactinemia as an adverse effect of dopamine receptor blockade may be reduced by some agents, limiting galactorrhea and irregular menstruation. Finally, and perhaps most significantly, the atypical antipsychotics offer potential efficacy in a broad range of nonschizophrenic illness. Olanzapine is now indicated for the treatment of mania. Other investigations suggest efficacy for atypicals as adjuvants to or augmentations of antidepressants in the treatment of refractory depressed and anxious states, including dysthymia and obsessive-compulsive disorder.

Atypical antipsychotics are the next wave of psychotropic medications. Their introduction and appeal parallel those of the SSRIs in the treatment of depressive and anxious states. Just as SSRIs heralded a new opportunity for primary care physicians to treat depression and anxiety more effectively in nonpsychiatric settings, atypical antipsychotics hand those in primary care a new generation of safe and effective agents to offer our patients. Most of us treat, exclusively or collaboratively, some patients with thought disorders or other psychoses, but there is an ever-enlarging therapeutic circle for atypical antipsychotics that already circumscribes a significant portion of our practice. I suggest that we get up to speed on the indications, efficacy, clinical rationale, and differential prescription of these agents as soon as possible. A primer on this very topic will be offered in the *Companion* very soon. —J.S.M.